



CBHDA IST Solutions Working Group DRAFT Medium & Long-Term Recommendations

November 4, 2021

CBHDA's suggested medium and long-term recommendations, would either require more than a year's time to implement, or are intended to address the structural drivers of the felony IST wait list more comprehensively. Specifically, CBHDA proposes concepts here to prevent the likelihood of individuals with serious mental illness or substance use disorders from justice involvement, as well as to address their needs as quickly as possible in the least restrictive setting if and when they do experience justice system involvement.

It is important to emphasize that mental health and substance use disorder treatment services are voluntary, and require a willing participation by clients. Most often, the outreach and engagement activities needed to engage an individual into services are not Medi-Cal claimable, and so the rate of Medi-Cal service involvement for those who have reached the level of a State Hospital IST restoration is understandably low. For those who are more engaged into services, whether in outpatient services, Full Service Partnerships, or in other ways, the individual is simply less likely to become a State Hospital client, as engagement into those programs has demonstrated effectiveness in reducing justice involvement.

If you have any questions, feel free to reach out to Michelle Cabrera (mcabrera@cbhda.org). CBHDA proposes:

Proposed Long-Term Solutions:

1. **Dedicated and prioritized housing for county behavioral health to both prevent criminalization, and address the needs of individuals who are justice involved.** DSH has reported that approximately 65% of individuals on the IST waitlist were unhoused homeless prior to arrest. The condition of homelessness makes individuals who are seriously mentally ill far more likely to experience interactions with law enforcement, and ultimately to be on a pathway to criminalization.
 - a. **Dedicated Housing for Full Service Partnership treatment slots – *prevention*.** CBHDA believes that the single most straightforward, impactful investment the state can make to stem the inflow of individuals deemed felony IST is to establish a commitment to fund housing for county behavioral health Full Service Partnership treatment slots.

Currently, California counties have invested approximately \$1 billion annually in the Full Service Partnership model funded under the Community Services and Supports component of the Mental Health Services Act (MHSA). This represents approximately one half of all MHSA funding. Currently, approximately 65,000 individuals throughout California are engaged in a Full Service Partnership. According to a 2019 analysis of Department of Justice and MHSA FSP data, the Mental Health Services Oversight and Accountability Commission found that arrest rates for individuals with high-criminal justice interaction enrolled in FSP programs dropped by 69% while they were enrolled in the program.

Although individuals experiencing homelessness are a target population for FSPs, funding for housing, including rental subsidies, housing, and housing supports must either come from the existing MHSA FSP funding, or is drawn from other scarce county behavioral health funding sources. The result is that although FSPs can and do connect a significant portion of clients into housing, there are individuals who may be engaged into FSP programs and experiencing homelessness.

Because a full range of housing options will be needed to support FSP clients, CBHDA proposes the establishment of a flexible housing fund that can be used to support a range of housing options for FSP engaged clients.

If the state were to make a commitment to fund housing solutions for each county behavioral health enrolled in an FSP, MHSA CSS funds could also be used to fund additional treatment slots, increasing the reach of the MHSA investment into treatment, engagement, and other “whatever it takes” elements of the program’s success.

- b. **Align state housing policies with DSH objective to improve community based treatment and restoration.** It is well understood that federal HUD definitions of homelessness exclude individuals transitioning from incarceration and therefore stymy efforts at the local level to ensure available housing resources are available to serve this population. In addition, while CBHDA strongly supports the Housing First policy generally, these policies can be especially challenging for individuals who may need to comply with the terms of probation or parole in order to avoid further justice involvement and these policies often create unintentional barriers around developing additional sober living residences for county behavioral health clients. Finally, NIMBY responses to proposed development of new housing have been significant barriers to developing the housing options needed to house county behavioral health clients, especially those with justice involvement.

CBHDA recommends that the state improve the prioritization of housing resources for individuals who are seriously mentally ill and/or have substance use disorders by conducting a comprehensive review of housing funding criteria to ensure that individuals with behavioral health conditions served by county behavioral health are explicitly included as a priority population for housing resources, and to remove barriers to housing individuals upon reentry from DSH or a correctional facility. This includes a review of licensing and citing policies, as well as developing a process to expedite the development of new housing and treatment facilities needed to support community-based restoration efforts.

- 2. **Improve discharge planning and transitions from DSH to county behavioral health.** Counties request that DSH make significant improvements to its own processes for discharge planning and coordination with local partners.

Currently, there is very little communication between DSH and local behavioral health agencies when an individual is being discharged from the state hospital. When county behavioral health receives information on an individual, it typically includes information related to charges, but is lacking in diagnosis, health, medication, and other relevant information to ensure a safe transition to the community. This includes when an individual has been found unrestorable, or when an

individual is being discharged to the community for any reason. Typically, DSH may communicate and coordinate with local courts or law enforcement around an individual's release, but a standard warm hand-off to county behavioral health with a complete client packet and planning around housing, medications, and other transition needs is needed.

Given the significant vulnerability of the DSH population, particularly to homelessness and justice involvement and the direction to this workgroup to identify solutions to interrupt the cycle of criminalization for individuals with serious mental illness, improved discharge planning around reentry post-discharge from DSH must become a higher priority for DSH. County behavioral health has been in the process of improving communication and discharge planning with CDCR, and can draw from those experiences to inform and improve DSH discharge planning and coordination.

- 3. Expand funding for AB 1810 Mental Health Diversion by \$500 million.** In 2018, The California State Legislature passed AB 1810, (Committee on Health) (Chapter 34, Statutes of 2018), which established pre-trial mental health diversion in California for individuals with mental disorders. This created an opportunity to reduce the number of individuals in California's jails and prisons with a mental illness. AB 1810 creates a pathway for courts to authorize pre-trial diversion for individuals with serious mental disorders who have been charged with a misdemeanor or felony crime and there is a nexus between the charged offense and the individual's mental illness, a qualified mental health expert states an individual will benefit from treatment, and the individual is not an unreasonable risk to public safety. Under AB 1810, the individual is diverted into mental health treatment for up to two years and upon successful completion of the program, the individual's charges will be dismissed. AB 1810 did not include a budget allocation to fully fund this alternative to incarceration.

With half of all felony ISTs being arrested more than 15 times, we believe that there is an opportunity to intercept them earlier in their trajectory with targeted investments in pre-trial mental health diversion for misdemeanants and felony charges where the individual is not found IST or not likely to be found IST. Financing for this program must include funding for both county behavioral health services, housing, and for courts to be appropriately funded to process diversion cases. Examples of eligible uses of the funding might include, but would not be limited to:

- Specialty Courts/ Forensic Assertive Community Treatment (FACT) teams
- Peer supports
- Post-booking public safety risk assessment
- Post-booking screening and clinical assessment
- Public defender case management
- Housing and housing-related services
- Treatment beds
- Wrap-around services
- Vocational services
- Capacity-building, including training, IT infrastructure, data sharing and evaluation
- Co-occurring treatment needs including substance use
- 15 days of in-jail treatment pending transfer to a diversion program
- Staff training for competencies in working with a forensic population
- Expungement of criminal justice record upon completion of the program
- and Sequential Intercept Mapping.

4. **Require standardized Community Program Director assessments in partnership with county behavioral health to facilitate referrals into local community-based restoration.** DSH currently has contractors statutorily required through CONREP to provide placement decisions for felony ISTs on the waitlist. We believe that this is a good opportunity within DSH's existing process to facilitate referrals to the local level in partnership with county behavioral health. We recommend the following:

- a. Amend statute to require Community Program Director, to provide recommendations regarding placement based on a level of care determination that prioritizes the least restrictive placement appropriate for the health, safety and risk to the individual and the community, and to consider the availability of community-based restoration and treatment options, including county community-based restoration and JBCT.
- b. Establish guidelines and criteria for CPD level of care determinations, including factors to consider when recommending placement at a state hospital, JBCT, or community-based restoration. Decisions to place individuals in the community, 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. Recommended 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 in jail 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.

5. **Expand the use of IMOs and LAIs, when appropriate, in jail settings.** Penal Code (PEN) Section 2603 allows for the use of involuntary medication orders approved by the court. However, there have been challenges in implementing this option across the state including hesitation from jail staff and contracted jail health providers, resourcing difficulties, lack of designation of jail as treatment facility under PC 1369.1, dedicated space to administer medication and provide monitoring, and inability to transfer patients to county hospitals or dedicated jail units of hospitals to administer medication. In addition, too few jails are administering long-acting injectable medication for individuals under an IMO.

These barriers result in individuals that could benefit clinically from the use of an involuntary medication order being more likely found IST and sent to the state hospitals if charged with felonies.

- a. **DSH Training and technical assistance.** Assistance from DSH in training, clinical staff capacity, and leading the conversation to bring the parties involved to the table to spread the use of involuntary medication orders across the state could lead to much earlier stabilization of individuals that could be diverted into the community rather than going to DSH. Specifically, CBHDA recommends DSH provide technical assistance to the Courts to strengthen their understanding of, and to develop procedures for IMO orders issued pursuant to PEN Sec. 1370.01.
- b. **Expand the use Long-Acting Injectables in Jail Settings.** CBHDA believes that a simple fix would be to partner with counties to establish new requirements and incentives to increase the use of long acting injectable (LAI) medication for individuals under an IMO. Long acting injectable (LAI) medications have been proven to prevent future treatment

resistance, prevent relapse, and improve medication adherence. In addition, LAIs reduce the need for the staffing and risks to incarcerated individuals and staff posed by daily administration of involuntary medications, , and prevent diversion of medication. Given their efficacy, LAIs should be more broadly adopted as part of the formulary for jail treatment settings. As a part of this strategy of adoption, the state should monitor and report the rate at which jails achieve the following:

- **Adoption of LAIs as part of the jail-based treatment formulary.**
- **Updates to policies and procedures to encourage the use of LAIs when appropriate, including for any individuals with early psychosis.**
- **Establishment of any new staffing, including training and updated policies and procedures to support the administration of LAIs as part of IMOs.**

6. Improve the Quality of Alienist Evaluations.

- a. **Statewide Certification Requirement:** CBHDA recommends establishment of a statewide alienist certification process to be overseen by DSH, contracted for operation through a third-party public university or non-profit organization, including developing the curriculum for the workshop. DSH should establish the statewide requirements including the qualifications, practice guidelines, curriculum, and core competencies required of the certification process, in consultation with county behavioral health, psychologists, psychiatrists, and Judicial Council of California, by July 1, 2022. In order to determine the curriculum of the certification program, DSH should be required to establish a curriculum committee to develop the initial and ongoing requirements for certification to complete competency evaluations. This curriculum committee should include, but not be limited to, representatives from county behavioral health, DSH, national competency experts, psychiatrists, and psychologists.

At a minimum, the curriculum committee should consider the following elements as part of the curriculum:

- Virtual Competency Evaluation Training;
- Site visits to DSH facilities (recommendation aligns with Massachusetts certification);
- Individual alienist mentoring;
- Report peer review;
- Renewal process with built out continuing education; and
- Ongoing quality assurance by DSH per CBHDA and CSAC's additional recommendations

CHBDA recommends DSH provide ongoing quality assurance of evaluations through providing continuing education training requirements for certification and the ability to independently assess and provide TA on evaluations. Once the certification program is established under a third-party public university or non-profit organization in California, there should be a limited timeframe allowed for current alienists across the state to become certified to continue to receive the rate increases described in the short-term solution.

- b. **Additional Funding for Alienist Evaluations.** Currently, the workforce required to perform alienist evaluations is in high demand statewide. Because the amount paid to alienists varies considerably by county, (counties report that alienists are typically paid in the range of \$375-\$750 CBHDA recommends increasing funding to ensure a floor of \$1,000 per evaluation and a base rate of \$150/ hour for evaluation and testimony required by the alienist. CBHDA also recommends DSH establish regional rate schedules across superior

courts in order to account for workforce shortages in rural communities, cost of living, and other cost of business factor differences between counties. These increased rates should be time-limited with future rate increases contingent upon alienists acquiring certification by 2024.

- c. **Require all evaluations to include consideration of malingering.** This could include the recommendation that alienists/evaluators use a validated tool to assess malingering such as the Structured Interview of Reported Symptoms, 2nd Edition or Personality Assessment Inventory, M-FAST or other measure, behavioral observations, record review, collateral interview, or other source of information.
- d. **Increase Diversity of Alienists and Language Capacity.** CBHDA and CSAC strongly believe that evaluators and the overall behavioral health workforce should reflect the communities served. As the state looks to expand the alienist workforce and improve the quality of reports, we need to be conscious to promote diversity and also add alienists with language capacity that reflects the language needs of those individuals requiring competency evaluation.
- e. **Require DSH to Directly Contract with Alienists to Complete Competency Evaluations.** The DSH currently contracts with forensic evaluators to complete sexually violent predator (SVP) and offenders with mental disorders (OMD) assessments. This model under Welfare and Institutions Code 6601 requires DSH to designate psychologists to evaluate individuals if they meet the criteria of an SVP, utilized a structured standardized assessment protocol, developed, and updated by DSH. Currently DSH holds an annual 4-day training for SVP evaluators.

We believe that in the long-term there is a strong benefit in having DSH directly contract and oversee alienists performing competency evaluations as this will allow the state to standardize and improve the quality of competency reports across the state, while maintaining a flexible pool of competent contracted alienists.

- 7. **Consider consolidation alienist evaluations and community program director evaluations.** Currently, individuals must undergo multiple, uncoordinated evaluations which are duplicative at a higher financial cost, and which creates unnecessary delays. In order to expedite the process of individuals with felony charges moving through the competency process, CBHDA and CSAC recommend that the state could consolidate the evaluation performed by the alienist and the evaluation performed by the DSH contracted community program director which is used to determine whether an individual should undergo outpatient treatment or be committed to DSH under Penal Code Section 1370 (a) (2) (A).

The current evaluations by the Community Program Director cause additional delays in the individual receiving competency and treatment services and it is unclear what grounds the existing CONREP programs are evaluating where individuals should receive services. CBHDA and CSAC request additional information on the differences between these evaluations to further assess whether a consolidated single evaluation has merit.

Based on the experience of county behavioral health departments, it appears that consolidating these functions and as well as alienist contracts under DSH will create more equitable access to evaluators across the state and allow for a more centralized quality management and oversight structure.