

**Incompetent to Stand Trial Solutions Working Group
Work Group 3: Initial County Competency Evaluations
Friday, October 15, 2021 – 2PM to 4PM
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 John Freeman and Jennifer Brya. She thanked everyone again for their dedication to this process and this population. She reviewed the meeting's agenda and said the central goal is to increase clarity of proposed solutions as well as look at long-term solutions. She reminded the group of their overarching goal, which is "to reduce the number of individuals found IST by strengthening the quality of the initial county competency evaluations." Recommendations out of this group will appear in the report due at the end of November.

Karen Linkins asked members of the working group to introduce themselves. All members were present except Katherine Clark, Todd Schirmer, Neil Gowensmith, Scarlet Hughes, and Jonathan Raven. The members in attendance were:

- Co-Chair Charles Scott, Chief of Forensic Psychiatry at UC Davis and Consultant to DSH
- Co-Chair Katherine Warburton, Forensic Psychiatrist and DSH Medical Director
- Deanna Adams, Judicial Council of California
- Francine Byrne, Principal Manager of the Criminal Justice Services Office at the Judicial Council of California
- Matthew Greco, Deputy DA of San Diego County
- Stephen Manley, Superior Court Judge of Santa Clara County
- Farrah McDaid Ting, Senior Legislative Representative for the California State Association of Counties
- Danny Offer, NAMI California
- Ira Packer, Forensic Psychologist, UMass Medical School Psychiatry Department, Consultant to State of California
- Dawn Percy, Deputy Director for Department of Developmental Services

- Stephanie Regular, Assistant Public Defender for Contra Costa County, representing statewide association
- Marni Sager, Manager at DDS in the State Operated Facilities Division

2. Recap Goals of this Working Group

Karen Linkins reminded group members that they are one of three groups and while there is overlap between them, their specific group's focus is on initial competency evaluations, however in this meeting it is important to draw connections and think about the larger picture. She emphasized that their purpose is to discuss solutions, not provide oversight. She also welcomed solutions from non-members in attendance in the chat. She asked that the Zoom chat not be used by workgroup members to communicate so their contributions can be heard out loud. She reviewed the timelines for solutions: short-term to be implemented by April 1st, 2022, medium-term by January 10th, 2023, and long term by January 10th, 2024 or 2025.

3. Recap of Last Meeting's Highlights and Short-Term Strategies

Karen Linkins reminded the group that after the last meeting, they were sent a spreadsheet with suggested solutions. No comments were submitted in relation to that spreadsheet so she said she hoped they would dive into that today. She recapped some of the work up to this point:

- Karen Linkins showed a slide with a breakdown of the number of solutions by timeline and work group, and also showed a breakdown of these solutions by category (funding, TA, operations changes, etc).
- Karen Linkins reviewed that the presentations in this work group's previous meetings revealed that there are widespread quality issues with evaluations, such as a lack of inclusion of DSM diagnoses and minimal use of structured assessments.
- Karen Linkins showed a slide with examples of short-term solutions proposed so far by members include implementing state-run TA and triaging the waitlist. Katherine Warburton added that many of these suggestions are doable right away. Karen Linkins asked if anything essential was left out of the list of the short-term solution list and nobody raised anything.

4. Discussion of Medium to Long-Term Strategies

Karen Linkins displayed a slide of medium-term solution examples, which included increased funding and statute changes. Group members discussed these solutions:

- Katherine Warburton added that increased funding must result in increased quality and a mechanism should be identified to ensure this.
- Charles Scott recommended that evaluators be given a checklist to follow in their training and quality review be done to measure reports against those expectations.
- Farrah Mcdaid-Ting said the final report should include which central entity will be responsible for the different pieces of these solutions, particularly around conducting training and quality review. Karen Linkins asked if she had a suggestion for which entity this should be, to which she replied that she did not and noted that while DSH would be logical, they have a lot on their plate.
- Stephen Manley pointed out that while funding to improve quality is important, they also need to prioritize funding the hiring of more evaluators to expedite the timeline of reports as that is currently a large issue that draws out lengths spent in jail.
- Charles Scott asked if anyone had thoughts on how long a reasonable time frame would be for a quality assurance and evaluations.
- Stephanie Regular said she thought a reasonable timeline would be 15 days but in her county their current time frame is 7 weeks. She agreed with Judge Manley that while better quality is needed, it could extent this timeline even longer. She cited one county that does short form reports for repeat patients, compared to their general longer form ones.
- Matthew Greco said that in the Forensic unit in San Diego they have a 6 week turn-around time which he believed to be typical, even in LA, but there are some exceptions to this such as when competency issues come up during a trial and that person it moved to the front of the line.
- Ira Packer asked to clarify what people meant by a 15 day timeframe. Judge Manley said 15 days from when the order is made/the time until the next hearing date. As of now, people ask for continuances which delays the next hearing date. Ira Packer said that in some jurisdictions there are two separate timeframes specified, which are the time between a judge's order to the evaluation and the time between an evaluation and a report. They are generally able to do this is 15 days. He said it would be helpful to have time limits for each piece.
- Stephanie Regular said she had meant 15 days from the assigning of a doctor to the completion of the report since the initial evaluation is only one piece of the process to

get a commitment order. She said some counties like LA have made it easier for alienists to see clients by not requiring they go into the jail as that requirement can cause delays. She recommended same-day evaluations by having alienists in the court room.

- Matthew Greco said his number of 45 days for SD is from when a doubt is raised until the 1360 hearing. Continuances usually only happen when defendants refuse to appear. Since all evaluations are done by their staff, assignments are automatic.
- Francine Byrne raised the issue that the system is not currently set up for courts or the Judicial Council to monitor evaluator quality and exclude low-quality evaluators, which she believed the current suggestion around funding would require.
- Deanna Adams said regarding evaluation timelines, LA county uses preliminary evaluations by evaluators within jails. While these reports leave some things out, they may be worth considering, which may require some changes to penal code.
- Judge Manley said short form reports would be a helpful tool as well as having evaluators in courtrooms.
- Katherine Warburton said these are all important points but improving the quality of reports may reduce the length of the waitlist which is the group's goal. She wants to make sure that solutions from this group address how to ensure that everyone on the waitlist should be there.

Karen Linkins said they will now talk about the statutory and administrative/operational changes that would be required to implement suggested solutions. She displayed a slide with all proposed strategies and a column to fill in needed changes. She said the conversation that just ensued about precise meanings was helpful in terms of identifying nuance and the level of detail and shared understanding needed. A conversation on needed changes followed, which primarily focused on Strategy 1: "Establish medicated (increased) funding pool with standards and quality oversight to support increased funding for and quality of reports":

- Judge Manley agreed with Francine Byrne's concern about where this responsibility will be placed and what the role of the courts will be. He said that in his county they have a committee with representatives from multiple bodies that interview evaluators. He agreed that all funding coming from the court is challenging because there is no specific line item for this in a court's budget. He suggested that the committee model his county uses is not the ideal one to replicate. Currently, the Judicial Council must ask for increased funding and he asked if that would stay the same under this suggestion (which he said is not the right fit currently) or if the responsibility would be moved to DSH or another entity. He said this would likely require statutory change.

- Francine Byrne agreed that there is no mechanism in place currently for the Judicial Council to play this role. She noted that there are some courts that are desperate for alienists and are doing very active outreach. She said that while they are related, funding and quality need some separate considerations. She recommended starting with the funding then having a longer conversation around the quality issue. With the funding, a position could be established that would work on this and centralize the list of alienists.
- Stephen Manley said he agreed with Francine Byrne because courts in many counties cannot find enough alienists and cannot pay them sufficiently. He agreed that funding and quality oversight need to be separated so centralization can happen first. He said he wants the trial courts to not have the majority of responsibility, as they cannot offer training, etc., and most do not have the staff capacity of San Diego.
- Katherine Warburton said the anecdotes about difficulty finding qualified evaluators make sense with the insufficient quality of reports. She said her primary concern is getting people off the waitlist who should not have been found incompetent in the first place. She said that from DSH's perspective, tying funding to quality makes sense as a solution. She asked those who think it is not a solution what accountability for quality should look like instead. They have tried adjusting regulation and rules of the court with no success. She suggested as one idea that if a poor quality report is submitted, then DSH can decide that the defendant not be added to the waiting list.
- Stephanie Regular said she believed Katherine Warburton's suggestion would raise a due process issue by denying treatment due to a bad report. She also raised frustration with the idea that poor quality reports are resulting in people being wrongly admitted to state hospitals because it assumes that public defenders, district attorneys, and judges are not doing their jobs. She said that she doesn't want to subject clients to the waitlist if it is not necessary. She disagreed that improved quality necessarily leads to a reduced waitlist because she has seen that poor quality is more likely to falsely find competency than incompetency. She also disagreed with the notion that medication is a catch-all approach that restores people to a state in which they are ready to be released because psychosis is not the only thing that people are struggling with and they have needs related to trauma, etc., that only emerge after medication.
- Karen Linkins asked Charles Scott if he had thoughts on the comments relating to the availability of evaluators. He replied that he understood the concerns raised. He suggested that the pool of university forensic (psychology and psychiatry) program residents, with supervision, could be a possibility for growing the evaluator pool. He had an experience like this in the army conducting evaluations under supervision.
- Matthew Greco said Katherine Warburton's suggestion of DSH monitoring quality by withholding waitlist entrance for bad reports could make sense if it also included a provision that allowed counties with an insufficient evaluator pool to borrow DSH psychologists and psychiatrists to do the initial evaluations. Then they would not need to

be checked by DSH because they would be conducted by them in the first place. DSH could then be the holders of this additional funding and could conduct remote evaluations where allowable. Buy in would be needed by counties and DSH would have to bring on new hires.

- Katherine Warburton said that this work group is part of the larger whole that is responding to the crisis of criminalization created by the increased arrests of people with mental illnesses and increased number of IST referrals. DSH has found a pattern of people being wrongly sent to state hospitals. She said that not only are people accumulating in jails, some do not need to be there because of poor report quality. She asked people to stay focused on providing solutions to this problem. She said perhaps not all members of the groups can agree on where the problem lies, but the purpose of the workgroup is about improving quality of reports and it would be purposeless if that wasn't a problem.
- Michelle Cabrera posted in the chat that her county BH experience shows that there are quality issues that falsely conclude incompetency. She then spoke and said that this problem has been known to their county BH for a long time. Her team had recommended a minimum required checklist for evaluators. She said that quality control has many elements including who is hired, what exactly is their understanding of IST requirements, and how will they be held to baseline standards. She said that ideally a certification process should exist with ongoing monitoring. Her team has also suggested that they find a way to merge the alienist and Community Program Director evaluations to make an immediate recommendation about a treatment path.
- Ira Packer said that data could be gathered to provide an answer to the disagreement over whether or not there is a quality problem that results in false declarations of incompetency. He suggested asking each evaluator what percentage of people they evaluate are incompetent.
- Stephanie Regular said that if data are gathered, they also have to incorporate whether or not a court rejects the finding. She said that DSH and courts at times disagree on if a patient is competent. She stated that she agrees quality of reports is low and should be improved but also thinks the group should be able to disagree. She said there are many problems and suggestions that they have not yet gotten to, such as that different entities are competing for doctors and whether or not alienists should suggest diversion. She said suggesting diversion should extend to CONREP because the defense pays evaluators more to recommend diversion than they get paid to do competency evaluations which pulls away the labor source.
- Karen Linkins said there is a theme of the need for more research, which should include understanding how many evaluators there actually are across the state.

- Judge Manley said they need clarification on the role of CONREP in this process. He said a diversion decision should be made at the same time or directly after the competency decision. He said that CONREP gives placement recommendations, which in his county, is always state hospitals. He noted that judges can override this but CONREP is not currently furthering diversion efforts and perhaps their role should change.
- Katherine Warburton suggested that a statutory change may be needed to solve this problem related to CONREP.
- Laura Jose, in attendance as a member of the public and a Public Defender in Orange County, agreed with Stephanie Regular and Judge Manley that diversion opinions should be tied into competency reports. She seconded that CONREP should have a different role because they never recommend diversion in her county which makes her job more difficult since the Judge then needs to be convinced that diversion should still be considered.
- Katherine Warburton said that DSH believes diversion is the only real solution to the cycle of criminalization, as they see many people found IST on felony charges for minor crimes resulting from their symptoms. DSH has funded diversion programs, but barriers are preventing many people from being diverted who DSH considers eligible. She agreed with the suggestion that a diversion opinion be connected to a competency opinion.
- Judge Manley said regarding solution 4, he believes the diversion statute allows the court to divert at any point in the proceeding. He said the diversion decision should be made during the placement hearing. He also suggested a statutory change that makes diversion the default and a Judge would have to provide reasons against if they did not think the person should be diverted rather than reasons for.
- Matthew Greco said he believed Judge Manley was referencing PC 1370 subdivision A that says that courts may consider diversion if they believe it would be beneficial and the suggested amendment is to change "may" to "shall." He disagreed that it is that simple because the courts would then have to make that consideration regardless of what information they receive (or do not receive).
- Stephanie Regular agreed with Katherine Warburton that diversion is the solution to breaking the cycle. She said it would help if DSH or CONREP recommended diversion more often. There are many problems with county capacity and risk aversion, but increased recommendations for CBT could really help get more people treated in communities.
- Katherine Warburton said that 47% of the waitlist should be considered for diversion but not necessarily diverted because this is dependent on the results of the risk assessment. She also said that DSH offers a virtual reevaluation service through which

they do recommend consideration for diversion, which is available to all interested counties.

- Stephanie Regular clarified that her request is that DSH recommend people to be diverted rather than to be considered for diversion, as they have already done an evaluation to make the recommendation for consideration. It would then be up to counties to determine a treatment plan.
- Judge Manley addressed Solution 9 which recommends treating some “low-level” felonies as misdemeanors. He said he is concerned that if they are treated as misdemeanors, the court has very few alternatives other than to dismiss the case and there is not a clear path to get these people treatment. He called for greater investments into community treatment to accomplish this. He said that the misdemeanor IST system is terrible, but SB 317 is a step forward, yet there are not adequate resources.
- Mark Gale, a member of the public, said that psychologists have continually tried and failed to get the ability to prescribe through the legislature. He said that as a dad, he wants a psychiatrist rather than a psychologist writing IMOs. He also said he liked Charles Scott’s idea about using students in forensic residency programs.
- Katherine Warburton clarified that the recommendation was not that psychologists be able to prescribe, rather that clarification is needed that psychologists do in fact have the ability to give opinions on patients’ capacity.

Karen Linkins invited the group to discuss long-term solutions. She asked that suggestions include the problem, the potential strategy, and what changes would be needed to implement it. Discussion followed:

- Charles Scott recommended that the workforce should be expanded by recruiting from residents at qualified universities. In some counties, they may not meet requirements to conduct evaluations so requirements would need to be reviewed. He also emphasized the “divert to what?” question and the need to expand community treatment capacity.
- Deanna Adams said that in addition to workforce expansion, retention is an issue. She said getting people still in training to learn how to conduct evaluations as well as creating retention incentives may help.
- Karen Linkins asked if anyone had ideas for other funding streams that could be leveraged for workforce expansion/retention.
- Farrah Mcdaid-Ting said that from a county perspective, particularly county mental health, there is no funding to spare.

- Deanna Adams said regarding Francine Byrne’s previous comment, the funding is paid through the court and statutory changes may need to be made, as currently statutory language designates trial courts as the “au pairs” of alienists.
- Farrah Mcdaid-Ting said that they may want to look at grants, philanthropy, and partnerships with educational institutions (for funding as well as workforce).
- Judge Manley suggested looking to figure out how to get MHSA funds. He said he supports the fellowship idea and thinks that if funding is obtained, it can be a short-term solution, and he already knows universities that will participate. His county did this for a period of time with temporary MHSA money.
- Stephanie Regular agreed that using residents is a strong idea and said that they do it in Contra Costa but it took 6 years to put into place. She said that the ultimate long-term solution is housing. Community programs need to be expanded but housing is essential in establishing enough stability for people that treatment can serve a purpose.
- Charles Scott said that he suggested the fellowship may be long-term because there is an accreditation council that has a long approval process.
- Michelle Cabrera said that MHSA has been unreliable but robust in recent years (\$2B) and county BH uses half of it for MediCal requirements and the other half for programs/services that are not reimbursed through insurance. It is not able to fill all holes that people want it to. County BH helped pass a bill this year that increases the share of MHSA money that can be used for substance use disorders. She emphasized the need to think of other funding sources since MHSA is spread thin.
- Stephanie Regular read a suggestion from the chat that early intervention needs to happen to disrupt the cycle before people get arrested. She added that there need to be sites other than jail where people can go and get treatment.
- Matthew Greco said that San Diego just opened a community-based crisis stabilization unit that police or civilians can bring people to. Several hundred people have been brought in and it just opened at the beginning of October. It was difficult to achieve buy in from municipal partners and it is incredibly complicated, but it is a long-term solution that aims to break the cycle. San Diego is already set to open a second one.

Karen Linkins said more input is needed from all members as their contributions are helpful in understanding the nuances. She assigned the group to comment and add information to these strategies for homework .

5. Call for Public Comment

Karen Linkins opened the floor to public comment on any agenda item but encouraged comments that relate to strategies and/or include suggestions. through either raising hands in Zoom, commenting in the chat, or emailing:

- Mark Gale agreed with comments by Michelle Cabrera and Judge Manley. He said the long-term solution is to stop people from entering the criminal justice system but the mental health system in California is unfinished. 25 counties have no psychiatric beds and there is a general shortage of IMDs. This population the group is talking about doesn't receive many MHSA funded services. He said there needs to be a workgroup like this one that identifies how to build out the state's mental health system in a 5 and 10 year plan. Part of this is the workforce crisis, which this group cannot solve. Only after the system is built out can people go to treatment in large numbers rather than jail.
- Martin Fox agreed that recognizing the impacts of 1991 realignment legislation is important. Before 1991, family members could seek help from state hospitals directly and a patient didn't need to interact with the criminal justice system. The Lanterman-Petris-Short Act have changed behavior incentives. He emphasized that families are an untapped resource to engage, and this is more important even than housing. He said that family engagement happened when people returned from Vietnam and a similar system should be in place.
- Teresa Pasquini thanked the group and said that she has personal experience with this topic and has spent a long time thinking about solutions. She expressed frustration at the conflict between the state and counties. She said she appreciated everyone on the call but doesn't feel that lived experience is being incorporated. She said she will share a report she wrote in partnership with another family member that suggests solutions.
- Deedrea Edgar said that there is a good deal of data collected by DSH that shows that the root problem is that people are not getting the help they need in their communities, and it is made worse by a lack of housing. She said the data shows this is a larger problem than the quality of reports. She said as long as mentally ill people are arrested, the problem this group is trying to address will continue. She cautioned against creating barriers to admission including "raising the bar on incompetency" which she called "changing the diagnostics to fit our lack of supply." She noted how differently mental illness is treated from other health issues and that effects funding. She disagreed with the framing of the problem having to do with quality of reports, though she agreed that better quality control is a good thing, though not with the goal of reducing the number of people coming into the system. She said she hopes that the group prioritizes improving quality of care.
- Katherine Warburton replied that DSH has strong research, and the goal of this work group is not to deny admission, but to prevent people sitting in jail on the waitlist who

don't need to be there which research has showed is the case. The goal is not to change reports to deny needed admission.

6. Meeting Wrap Up and Next Steps

Karen Linkins thanked the group again for their comments and described that the home-work assignment is to flesh out more of the context, implications, and needed changes for each strategy. Karen Linkins reminded the group that the minutes and agenda will be posted on the website. She mentioned that there are still two meeting of the other two working groups and more meetings for the general work group.

Appendix 1: Chat Transcript

From John Freeman to Everyone: 02:09 PM

Welcome! Today's slides and agenda are available at:

<https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup/#october-15-2021-working-group-3>Materials for all of the working groups and the overall work group are available at: <https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup/>To share comments or to be added to the IST Workgroup email distribution list, please contact ISTSolutionsWorkgroup@dsh.ca.gov. Please use Q&A for technical issues only. For discussion items, please use the chat and we will address topics raised by participants as time allows. Public comment will be available at the end of the meeting.

From Michelle Cabrera to Everyone: 02:21 PM

As already submitted as a long-term recommendation: Consolidate alienist evaluations and community program director evaluations. Currently, defendants 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 defendants with felony charges moving through the competency process, CBHDA recommends 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 a defendant 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 requests 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.

From Michelle Cabrera to Everyone: 02:26 PM

CBHDA also submitted for medium to long-term: Require that Alienist Certification. CBHDA recommends establishment of a statewide alienist certification process to be overseen by DSH, contracted for operation through a third-party public university, 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 re-

quired 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.

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, 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.

From Laura Jose to All Panelists: 02:26 PM

In our Orange County it can take 6 to 8 weeks (or longer when orders get messed up) to get the two reports. It would be great if there was a standard model like LA County where there is an alienist available to quick evals for the most obviously sick clients. Often, the correctional health staff has already identify the person with a SPMI and they may be actively delusional, etc. No one needs two reports and an 8 week delay on these clients.

From John Freeman to Everyone: 02:39 PM

Apologies, all! My Zoom completely locked up. Seemingly better now.

From Michelle Cabrera to Everyone: 02:45 PM

That's not good.

From Teresa Pasquini to All Panelists: 02:49 PM

This was my experience with my son. The quality differences of the alienist reports was stunning. There is no accountability for the resulting suffering of ongoing solitary that resulted.

From Laura Jose to All Panelists: 02:51 PM

One reason you don't have doctors to do reports or quality reports is that they are not paid sufficiently. Most counties pay very little and it is difficult to get people willing to do reports.

From Teresa Pasquini to All Panelists: 02:51 PM

I strongly agree with Ms. Regular.

From Laura Jose to All Panelists: 02:52 PM

Agreed. As the supervisor of the mental health unit in our PD's office, we are not committing people who are not IST. We also continue to monitor our clients to see if they become more stable while waiting for commitment.

From Teresa Pasquini to All Panelists: 02:53 PM

Thank you so much for focusing on the individual and their family, Ms. Regular!

From Laura Jose to All Panelists: 02:53 PM

If anything, lawyers are hesitant to declare a doubt when they maybe should because of the terrible outcomes for our clients.

From Michelle Cabrera to Everyone: 03:00 PM

Our experience (county behavioral health) is absolutely that the quality is not there and there are individuals who have inappropriately been deemed incompetent to stand trial.

From Laura Jose to All Panelists: 03:08 PM

It would be extremely helpful if evaluations re: competency addressed MH diversion as an option. As we all know, Conrep, in most counties, never recommends outpatient treatment. To Stephanie's point, it could also incentivize dr.'s to do reports and get paid.

Spot on J. Manely!

From Michelle Cabrera to Everyone: 03:11 PM

This is a huge problem, Judge Manley. We have asked as well why we can't change the criteria used by CONREP to encourage diversion. We included this in our recommendations.

If we're going to invest in a diversion infrastructure we have to align the state processes and policies to support that desired policy direction. It's why we believe some of our diversion pilots have not been successful.

From Gilda Valeros to Everyone: 03:12 PM

CONREP has authority currently to recommend Community Based Restoration. They do not conduct in person evaluations, they have zero knowledge on community based restoration. They can fix the rate of referrals to DSH right now with no legislative fix.

From Mark Gale to Everyone: 03:13 PM

At the appropriate time, I have a public comment on the third bullet on IMO's

From Michelle Cabrera to Everyone: 03:16 PM

As a practical matter, I would think that the court also needs a quality evaluation to support the court's decision. This goes back to making sure we improve quality of the evaluation as we move toward any streamlining.

From deedrea edgar to Everyone: 03:20 PM

CONREP does not meet with patients, never recommends community placement, always recommends inpatient DSH filling your own wait list. DSH 3 year study data shows

the increase in people for waitlist is the lack of community treatment, not malingering, not drug abuse, not alienist reports. This committee should be talking about quality patient care to reduce recidivism, quality reports for treatment of people vs using your alienist report in a way to avoid ISTs to DSH, it sounds like making an alienist report of competency is your goal to deny treatment to incompetent sick people who are being criminally charged. Many IST people can be diverted for community treatments, but the courts will point to the criminal charges or rap sheets as a reason not to grant diversion because they are scared to grant diversion. Judges will just say "unsuitable" when the patient meets all the criteria to avoid releasing a patient to the community. Judges want the law to tell them they should.

DSH often sends patients back to the counties who are not competent, they provide foundational restoration, memorizing court players and how to take a plea deal, but are not competent on the psychological criteria of making legal decisions, remain decisional incompetency. This is a cycle needing quality at all levels for quality patient care, release them to community care and provide good community care if DSH doesn't want them there, but the courts and DAs prefer them incarcerated when there is no community placements and treatments.

From Matthew Greco to All Panelists: 03:21 PM

I believe that Judge Manley is referencing PC1370(a)(1)(B)(iv) - If, at any time after the court finds that the defendant is mentally incompetent and before the defendant is transported to a facility pursuant to this section, the court is provided with any information that the defendant may benefit from diversion pursuant to Chapter 2.8A(commencing with Section 1001.35) of Title 6, the court MAY make a finding that the defendant is an appropriate candidate for diversion.

From Mark Gale to Everyone: 03:22 PM

I have a comment'

From Lindsay Schachinger to All Panelists: 03:25 PM

Invest in community treatment —yes! We need community treatment that will accept inmates.

From Mark Gale to Everyone: 03:28 PM

Thank you Dr. Warburton.

From Michelle Cabrera to Everyone: 03:32 PM

We would need access to additional housing as well as community treatment options - particularly given the high rates of unhoused homelessness among this population. While there are housing resources being directed locally, it can be quite difficult to source and fund housing - particularly for individuals with criminal backgrounds.

From deedrea edgar to Everyone: 03:35 PM

Reduce arresting/prosecuting people with untreated mental illness and have the counties respond to untreated mentally ill people with a health care response such as civil commitments, local treatment interventions, just like we do with the elderly with dementia disorders. The counties don't respond to the mentally ill in crisis because they have no where to take them so they leave the police to arrest and incarcerate for disruptive behaviors untreated mental illness. Use money for community treatments, don't take the sick people to jail, then they won't go on a 1700 person wait list to DSH, invest in health care with all funds we know exist, take these disabled people out of criminal justice.

From Michelle Cabrera to All Panelists: 03:36 PM

I would like to speak to the MHSA funding suggestion.

From Mark Gale to Everyone: 03:36 PM

I have a long term idea

From Ira Packer to All Panelists: 03:38 PM

I have to sign off now.

From Mark Gale to Everyone: 03:40 PM

Revise the 1991 Mental Health Realignment formulas! May I comment about completing the mental health system

From Matthew Greco to All Panelists: 03:41 PM

<https://www.nbcsandiego.com/news/local/community-based-crisis-stabilization-unit-opens-in-vista/2733199/>

From Linda Mimms to All Panelists: 03:44 PM

Mr. Greco, the CSUs are great but do not solve the problem of getting those with anosognosia life saving care. Our AOT program does not serve the population it is intended for under Laura's law—the sickest who will NEVER voluntarily seek care. The IHOT system ONLY accepts voluntary patients. Our AOT program is a failure for those it is supposed to catch..

From Mark Saatjian to Everyone: 03:44 PM

I want to second Deedrea Edgar's observations.

From Michelle Cabrera to Everyone: 03:49 PM

Exactly - stigma makes it extremely difficult for us to build up services, even when we have the funding. We have asked the state to align its policy goals by giving us special expedited licensing and certifications. CSUs are a nice stop-gap in some cases, but we would urge you all to not look at it as a standalone solution. Federal funds can only be used up to 24 hours, and commercial insurance often doesn't reimburse. Oftentimes

costs are offset with MHSA funds. When you have this type of temporary crisis stabilization/receiving center, you need a place for throughput which is why it does go back to housing options as Stephanie raised.

Agree with Mark Gale in that we can't use MHSA for those higher level treatment facilities oftentimes. It can't be used for any locked treatment, so we do rely on 1991 realignment for that.

1991 Realignment mental health revenues for FY21-22 (\$1,134.6 million) are less than revenues received in FY04-05 (\$1,198.9 million).

From Teresa Pasquini to Everyone: 03:56 PM

Thank you for your comment!

From Gilda Valeros to Everyone: 03:59 PM

Thank you, Deedrea.

From Mark Gale to Everyone: 04:00 PM

Thank you everyone and for the opportunity to weigh in

From John Freeman to Everyone: 04:00 PM

Today's slides and agenda are available at: <https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup/#october-15-2021-working-group-3> Materials for all of the working groups and the overall work group are available at: <https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup/>

To share comments or to be added to the IST Workgroup email distribution list, please contact ISTSolutionsWorkgroup@dsh.ca.gov.

From Mark Saatjian to Everyone: 04:01 PM

Yes! Thank you Deedrea for so eloquently giving voice to so many vulnerable people!