IST Solutions Workgroup-Homework

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

- Short-term there may be no other solution than to utilize JBCT to reduce the current waiting list. However, for long-term planning, JBCTs should be phased out and replaced with new community-based facilities, both open and secure.
- The 775 LPS patients will require an adequate investment by the state and counties in residential treatment capacity. A short term solution is a significant hurdle, but an appropriate remedy must be found. They should not be returned to the counties until appropriate mental health residential facilities can be identified or constructed to receive these patients. The counties do not have anywhere to place these very ill individuals who will end up back on the street, and then the jail, and then back on the waiting list as IST. Counties do not have facilities with a state hospital level of care and returning them to nothing is not an option. The solution for these patients resides in creating the capacity to house and provide adequate treatment to these individuals in the community.

Working Group 2: Diversion and Community-Based Restoration for Felony ISTs

- Diversion residential programs should be constructed, developed, and operated using proven providers with positive outcome data. We do have high quality operators in the state and should emulate good programs. See “Housing that Heals” authored by Teresa Pasquini and Lauren Rettagliata.
- Mid-to-long term: CBR facilities must be constructed instead of JBCTs to facilitate the phasing out of JBCTs in the future. JBCT should not be the default treatment option for justice-involved persons with SMI. People do not get well in jail.
- Assisted Outpatient Treatment: Residential care for FIST diversion clients should be enhanced by AOT programs for some IST diversion clients.
- Longer term solution: We are dependent on outside contracted providers who refuse to take the most challenging clients. To remove the capability to “cherry-pick” clients and refuse clients from the jail, develop dedicated diversion residential housing specifically designed for the waitlist population, supported by state funding and administered by county mental health departments. Obviously, these clients would have been found to be DSH Diversion-eligible. Public clients, public solution.
- There are other forms of diversion programming in addition to PC 1001.36 that do require a plea arrangement. They should be considered as viable options for some.

Working Group 3: Initial County Competency Evaluations

- Alienist evaluation fee should be increased to acceptable levels ($750-1,000?) for all new evaluators who take the new training that is to be developed in the future. Existing alienist workforce should not receive the higher payout until they complete the new training program.

Additional Reforms

- We cannot solve this problem without reducing the flow of new justice-involved clients into the jails. Impossible to solve only on the back end of the system. Felony Incompetent to Stand Trial (FIST) individuals are there because they could not access higher levels of mental health care in the community. The mental health system failed them and so they became the revolving door client from the street to the jail to the inpatient hospital, back to the street and back to the jail, and so on. We have to provide access to the higher levels of care and the adequate capacity necessary to serve the large numbers of people in need. We never completed the mental health system in California which is why 25 counties have no psychiatric beds at all! The State of California should be responsible for its actions and the consequences of its decisions. Some potential remedies:
  - LPS Reform: LPS acts as a barrier to the levels of care that people experiencing severe and persistent mental illness require to become stabilized so they can be handed off to the outpatient system and complete their recovery. We need to reform the definition of “grave disability” as one important step in this process. Waiting for dangerousness almost guarantees that someone who is in a severe mental health crisis will end up becoming justice-involved. We don’t wait to treat cancer until someone is in fourth stage, why do we demand this of people coping with serious mental illness (SMI)? The law is a big part of the problem. We need to find the political courage to fix this. See LPS Reform Task Force II report “Separate and Unequal”
  - Resources and Funding: 1991 Mental Health Realignment Funding is the legal funding source for the treatment modalities and facilities that serve those who are the most sick. These revenues have been flat for many years and as Michelle Cabrera pointed out, they are lower today than in 2005. This is “fiscal discrimination” against the most severely ill people in our state, yet our political system does nothing to change this. Our state has caused this problem and we need to own it and finally remedy this causality of our mental health crisis in our state.
    - Reform 1991 Mental Health Realignment Funding and remove the inherent discrimination baked into our funding formulas. These funding decisions are choices and they have consequences.
    - Build out the acute and sub-acute levels of care in every county in California and finally develop the capacity we need to serve and treat our most seriously ill individuals living with serious mental illness. This can only be accomplished utilizing 1991 Mental Health Realignment funding and cannot be done with MHSA dollars.
    - Build out the residential treatment centers and housing opportunities that must be available for people to properly recover and thrive.
    - Increase funding for Public Guardian Offices that act as Conservators for this population. They are woefully underfunded and must be properly

staffed to serve a very challenging population of clients. This is an important component to developing a system of care that functions properly and provides clients with the care and supervision they need.

- DHCS must stop postponing applying for the IMD Exclusion Waiver. This must be done as soon as possible and the State of California should be lobbying Congress for a full repeal of the IMD Exclusion. This legalized discrimination must stop now! Support HR 2611 (Napalitano-D) in Congress.
- I endorse initiating a dialogue on an idea brought forth by Brian Bloom to seek legislative reform similar to SB 317 for all non-serious, non-violent individuals. It could have a large impact on the waiting list and is a much more humane way of dealing with the challenges faced by people who cannot escape the criminal justice system and their IST status. (Note: For those charged with these felonies, a level of judicial discretion and authority may need to be maintained to avoid the dismissal of charges for those who do not remain treatment compliant). Such reform could leave the state hospital system for serious offenders and violent individuals as well as the other populations that truly require that level of care.
- Very Long Term Goal: Re-imagining our State Hospital System
    - If we are able to get past this crisis and reduce the waiting list and free up capacity, it is incumbent upon us to ask "are we really using our state hospital system in the most effective way possible?" Using this state resource for 70% of the capacity to cope with the FIST population is insanity. The outcome from this travesty should be better and more useful than someone who is returned to a county to be tried and often just sent to prison where they do not recover and just become more seriously ill. Lots of effort, money and resources are going into an exercise and no one is getting better!
    - Why do we sentence serious and violent felons whose SMI was a substantial factor in the commission of the crime to state prisons that cannot deliver the level of mental health care they require? Since most come home someday, is this quality public policy? I think not. We should at least have a dialogue on sentencing some of these individuals to a state hospital instead of CDCR for both determinate and indeterminate sentences. The question, "Who should go to a prison and who should go to a state hospital?" must be part of our dialogue.
    - If we were starting from scratch, is this how you would want our state hospital system to be utilized? Where is our True North? Let's aspire to a better and truly reformed system.
- What other ways could we re-imagine our state hospital system? Right now, that discussion appears as an intellectual exercise for the future, but I am sure the expertise on this Workgroup could develop other ways to re-imagine DSH.

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